2015-2105

PRINTED: 12/28/2015
FORM APPROVED

Washington State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012792	A. BUILDING _____ B. WING _____	12/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRFAX BEHAVIORAL HEALTH MONROE	14701 179TH AVE SE MONROE, WA 98272

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 000	INITIAL COMMENTS INITIAL STATE LICENSING SURVEY This initial State hospital licensing survey was conducted 12/15/2015 - 12/16/2015 by Lisa Sassi, RN, MN; and Alex Giel, EHS, PHA. The Washington Fire Protection Bureau conducted the fire life safety inspection on 12/15/2015 ASE # 63P511	L 000	1. A written PLAN OF CORRECTION is required for each deficiency listed on the Statement of Deficiencies. 2. EACH plan of correction statement must include the following: The regulation number and/or the tag number; HOW the deficiency will be corrected; WHO is responsible for making the correction; WHAT will be done to prevent reoccurrence and how you will monitor for continued compliance; and WHEN the correction will be completed. 3. Your PLANS OF CORRECTION must be returned within 10 business days from the date you receive the Statement of Deficiencies. Your Plans of Correction must be postmarked by January 14, 2016 or sooner. 4. Return the ORIGINAL REPORT with the required signatures.	
L 410	322-035.1V POLICIES-FOOD SERVICE WAC 246-322-035 Policies and Procedures. (1) The licensee shall develop and implement the following written policies and procedures consistent with this chapter and services provided: (v) Food service consistent with chapter 246-215	L 410		

By signing, I understand these findings and agree to correct as noted:

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Rachel A Keyes — Chief Operating Officer — 1/13/16

Washington State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012792	A. BUILDING _____ B. WING _____	12/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRFAX BEHAVIORAL HEALTH MONROE	14701 179TH AVE SE MONROE, WA 98272

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 410	Continued From Page 1 WAC and WAC 246-322-230. This WAC is not met as evidenced by: Based on observation, the hospital failed to comply with Washington State Food Code WAC 246-215 when installing the ice machine in the nourishment room. Findings: During a tour of the hospital on 12/16/2015 between the hours of 9:30 AM and 12:30 PM, Surveyor #1 observed that the ice machine was not provided with an indirect drain with an air gap to the sewage line. At the time of the survey the facility was unable to provide information to see if the ice machine had an internal indirect drain with an air gap. Reference: WAC 246-215-05215 Design, construction, and installation - Backflow prevention, air gap (2009 FDA Food Code 5-202.13).	L 410		
L 710	322-100.1D INFECT CONTROL-PHYS ENVIRON WAC 246-322-100 Infection Control. The licensee shall: (1) Establish and implement an effective hospital-wide infection control program, which includes at a minimum: (e) A procedure to monitor the physical environment of the hospital for situations which may contribute to the spread of infectious diseases; This WAC is not met as evidenced by: Based on observation the facility failed to prevent cross contamination from patient care equipment that was stored in the bathtub/shower room.	L 710		

By signing, I understand these findings and agree to correct as noted.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012792	A. BUILDING _____ B. WING _____	12/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRFAX BEHAVIORAL HEALTH MONROE	14701 179TH AVE SE MONROE, WA 98272

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 710	Continued From Page 2 Findings: On 12/15/2015 between the hours of 11:30 AM and 12:30 PM during a tour of the facility, Surveyor #1 observed patient care equipment (patient lift) stored in the bathtub/shower room. After reviewing the Washington Administrative Code 246-322-120(8)(c) patient care equipment should be stored in a designated utility service area.	L 710		
L 780	322-120.1 SAFE ENVIRONMENT WAC 246-322-120 Physical Environment. The licensee shall: (1) Provide a safe and clean environment for patients, staff and visitors; This WAC is not met as evidenced by: Based on observation, and interview the hospital failed to provide an environment that was conducive to the safety of its psychiatric patient population. Findings: 1. On 12/16/2015 between the hours of 9:30 AM and 10:30 AM, Surveyor #1 observed a hand-held shower attachment in the shower/bathtub room. The attachment posed a ligature risk to potentially suicidal psychiatric patients. The facility did not have a policy to ensure patient safety in the enclosed, unsupervised environment. 2. On 12/16/2015 between the hours of 9:30 AM and 10:30 AM, Surveyor #1 observed that each patient room had rectangular clocks located above the door frame which posed a ligature risk to potentially suicidal psychiatric patients. The environment of care manager (Staff Member #1) stated that they were in the process of receiving	L 780		

By signing, I understand these findings and agree to correct as noted:

Washington State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012792	A. BUILDING _____ B. WING _____	12/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRFAX BEHAVIORAL HEALTH MONROE	14701 179TH AVE SE MONROE, WA 98272

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 780	Continued From Page 3 clock covers to prevent ligature risks.	L 780		

By signing, I understand these findings and agree to correct as noted: